DEPARTMENT OF CHILDREN AND FAMILY SERVICES

DISTRIBUTION: X and Z

POLICY GUIDE 2003.04

COMPREHENSIVE MEDICAID BILLING SYSTEM (CMBS)/ MEDICAID BILLING SYSTEM (MBS)

DATE: April 1, 2003

FROM: Jess McDonald

TO: Rules and Procedures Bookholders and DCFS and Medicaid Mental Health Service Providers

EFFECTIVE DATE: April 14, 2003

I. Purpose

In response to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) this Policy Guide is being issued to describe the Comprehensive Medicaid Billing System (CMBS) and the Medicaid Billing System (MBS) and who must use it.

II. Primary Users

The primary users of this Policy Guide are all providers of 59 Ill. Adm. Code 132, Medicaid Community Mental Health (MCMH) Services and DCFS staff who receive, handle or transmit Part 132 billing information.

III. What is the Comprehensive Medicaid Billing System (CMBS) and Medicaid Billing System (MBS)

The DCFS Medicaid Billing System is the system through which Medicaid services are claimed to DCFS and the Illinois Department of Public Aid (IDPA). Providers submit claim data concerning MCMH Services provided to children under their contracts. Claiming occurs on a monthly basis via computer diskette through the Department's CMBS/MBS. This information is due no later than the last State of Illinois working day after the month in which service was provided.

The CMBS/MBS involves the use of a personal computer system by each agency for entry and correction of the claims to be submitted. DCFS provides this software free of charge to all agencies involved.

IV. Using the CMBS/MBS

1) General Expectations of DCFS Medicaid Providers

Medicaid Community Mental Health Services providers submit billing data for the provision of Medicaid services to clients served under a DCFS Medicaid contract as follows:

a) **Submittal of Billings**: Medicaid providers submit billings for services in the format and medium specified by the Department no later than the last State of Illinois working day after the month in which services were provided. If the provider fails to submit the required billings, the Department reserves the right to suspend payment of the Medicaid portions of the rate, and/or to recoup monies paid to the provider for Medicaid services.

b) **Re-Submittal of Rejected Billings:** Medicaid providers re-submit billings previously rejected by either the Department or the Illinois Department of Public Aid for a correctable error on the next billing cycle due to the Department after the provider's receipt of notice of the rejected billings.

c) **Third-Party Payments**: All initial billings and previously rejected billings shall, as necessary, contain information concerning the amount of any payment the provider received from a third-party for services provided to an individual child.

2) Billings Processing By DCFS

When the Department receives billings from the provider as required above, the Department will edit the billings and return to the provider a file of records for correction within 15 days of the established cut-off dates. The cut-off date is the last working day of each month. Billings that are acceptable to this editing process will be forwarded to IDPA for approval.

3) Billing Requirements—Substitute Care Contracts

a) **Comprehensive Services**: Medicaid providers submit to the Department's Financial Management Division by the fifth working day of each month the Monthly Claim Statement listing of children served during the previous month and the inclusive list of dates of service for each child. The Monthly Claim Statement shall be the basis for determining the total amount of payment due to the provider based on the per diem rate. (The per diem rate consists of a Medicaid and Non-Medicaid/room and board portion.) Failure to comply with this section may result in payment interruption or contract termination. The provider shall submit Medicaid billings equal to or in excess of the total amount stated in the contract as support documentation for previous payments for Medicaid Community Mental Health Services. Therefore, the provider shall submit billings equal to or in excess of the number of days of care multiplied by the Medicaid portion of the rate.

Monthly payment for Comprehensive Mental Health/Rehabilitative Services will be made through the automated board payment system. The Department will prepare a reconciliation report for each DCFS Medicaid substitute care contract to verify that all billing information has been submitted and that any billings returned due to errors have been corrected and resubmitted.

If the provider fails to comply with the requirements for Comprehensive Services billing, service provision, or documentation requirements as outlined in the provider's program plan, the Department may revoke the provider's ability to provide Comprehensive Services. As a result, the Department may then require the provider to submit Fee-for-Service billing for Medicaid services.

The maximum Medicaid billings for which the provider may receive revenue is limited to the total days of care provided multiplied by the Medicaid per diem rate. Any Medicaid revenue received by a provider in excess of the reconciled Medicaid billings will be refunded to the Department or withheld from monies due the provider.

b) **Fee-for-Service**: Medicaid providers submit to the Department's Financial Management Division by the fifth working day of each month the Monthly Claim Statement listing of children served during the previous month and the inclusive list of dates of service for each child. The Monthly Claim Statement shall be the basis for determining the total amount of payment due to the provider based on the non-Medicaid portion of the full per-diem rate. Failure to comply with these requirements may result in payment interruption or contract termination.

The provider submits bills equal to or in excess of the total amount stated in the contract as payment for Medicaid Community Mental Health Services. Therefore, the provider shall submit billings equal to or in excess of the number of days of care multiplied by the Medicaid portion of the rate.

Payment for Medicaid Community Mental Health Services will be made on the basis of actual billing levels received and accepted by the Medicaid Billing System. The Department will prepare a reconciliation report for each DCFS Medicaid substitute care contract to verify that all billing information has been submitted and that any billings returned due to errors have been corrected and resubmitted.

For those billing months in which the billing reconciliation yields a net amount due to the provider, the Department will initiate a voucher payment. The maximum Medicaid billings for which the provider may receive revenue is limited to the total days of care provided multiplied by the Medicaid per diem rate. Any Medicaid revenue received by a provider in excess of the reconciled Medicaid billings will be refunded to the Department or withheld from monies due the provider.

4. Billing Requirements—Non-Substitute Care Contracts

a) **Counseling**: Medicaid counseling providers submit billing claims for services delivered to Medicaid eligible and non-Medicaid eligible clients served under the contract. Payments will be issued based on reconciled utilization information and a comparison with referral for service authorizations.

b) **SASS**: SASS providers submit bills for Medicaid Community Mental Health Services that equal or exceed a designated percentage of the maximum payable amount under the SASS contract. Payments will be issued based on the cash flow payment schedule outlined in the program plan.

V. Billing Processing

Once the CMBS/MBS billing diskette is sent by the provider to DCFS, the diskette is logged in as received by the Office of Contract Administration, Medicaid and Non-Board Services. The billing information is then uploaded on personal computer for initial verification of readable data. If the data is readable, a letter is sent to the provider confirming receipt and readability. The readable billing data is then batched and loaded to a DCFS mainframe "host" system. This billing data is then held until the regularly scheduled billing processing cycle. The mainframe and billing processing cycles are managed by the Department's Office of Information Systems. Reports by the Office of Information Systems are produced at several points in the billing processing cycle to provide a quality assurance check on the process. These reports serve to provide both alerts to any problems in the billing cycle (occurs two days before the final processing occurs) or actual print-outs regarding the results of the entire billing cycle.

Any reports that are generated are routed to the appropriate staff for monitoring/use. Report distribution includes the Department's Office of Financial Management for use in substitute care contract payment reconciliation and generation, the Office of Contract Administration for overall system integrity and interface with providers regarding the results of the billing cycles, and the Office of Contract Administration for payment and reconciliation on the SASS and Counseling contracts.

Any billings submitted via diskette that do not process cleanly through the billing processing cycle (e.g., because client names, ID's or other details are incorrect), are returned as errors to the Office of Contract Administration for error diskette generation. These error diskettes are returned to the providers for uploading onto their CMBS/MBS allowing for the error correction process described in section 1.b. above.

Once the billings are processed and verified as "valid" bills submitted by the provider, these valid bills are then submitted to the Illinois Department of Public Aid (IDPA) as Medicaid claims. IDPA then validates the claims against their system edits, and all valid claims are then submitted to the federal government for federal financial participation matching funds.

VI. Questions

MBS Technical Support

Computer system problems or software questions	(217) 524-3560

Office of Financial Management

Institution, Group Home, Foster Care & Independent Living payment questions	(217) 785-2704

Office of Contract Administration

Status of your billing or error diskette	(217) 524-3304
Counseling Contract billing or payment questions	(217) 557-2458
SASS contract billing or payment questions	(217) 785-0200

The Infant-Parent Institute

Medicaid Rule 132 interpretation or billing issues not specified above

Champaign	(217) 352-4172
Matteson	(708) 503-8431

VII. FILING INSTRUCTIONS

File this Policy Guide with Procedures 359, Authorized Child Care Payments, immediately following page P359.100 (2)

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